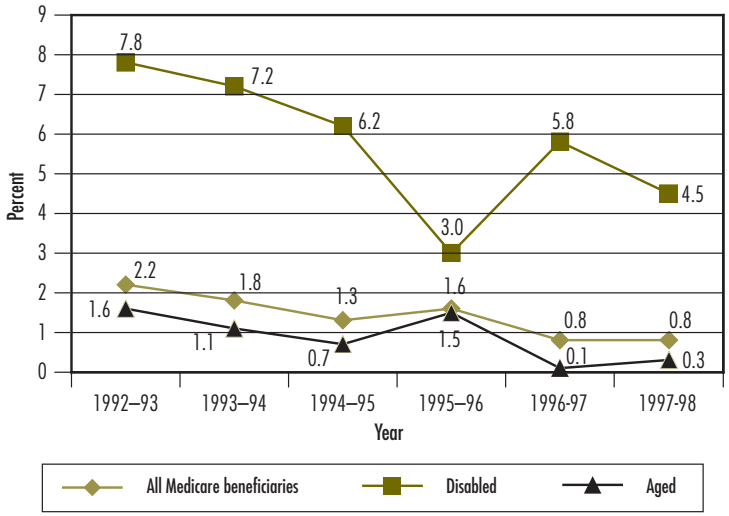
2 TRENDS IN THE MCBS: 1992–1998

THE MEDICARE POPULATION

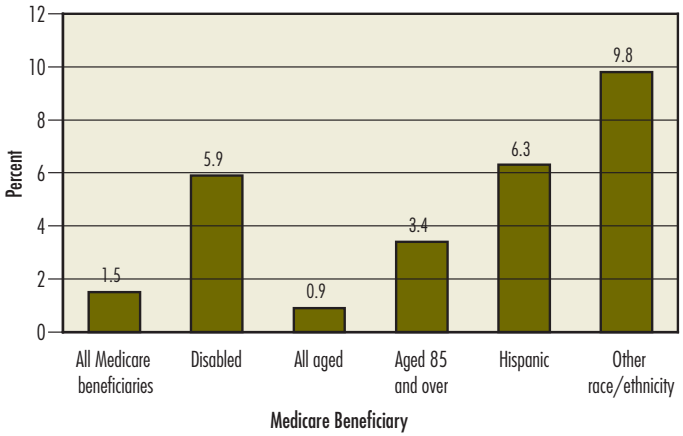
In 1998, the number of Medicare beneficiaries grew to an ever-enrolled population[1] of 40.1 million, representing 14.6 percent of the total U.S. population. Between 1992 and 1998, annual growth rates for the overall Medicare population remained modest, dipping below 1 percent since 1996 (Figure 2-1). However, the relatively flat growth curve masked the uneven growth rates for certain subgroups of the Medicare population, for example, the oldest old,[2] some racial/ethnic minorities, and disabled beneficiaries.[3] The Medicare population became increasingly diverse between 1992 and 1998, comparable to similar trends in the entire U.S. population.

Figure 2-1 Annual Growth in Medicare Population by Medicare Status, 1992–1998



The gradually declining growth rate for the aged Medicare beneficiaries (Figure 2-1) reflected the national trend observed for the 65 and over age group in the 1990s (U.S. Bureau of the Census, 1996).[4] However, the growth rate of the oldest old in the 1990s was often many times higher than that of the aged population as a whole. Figure 2-2 shows that the average annual growth rate for the oldest old was 3.4 percent between 1992 and 1998, compared with a less than 1 percent rate during the same period for the aged population.[5] Consequently, the proportion of the oldest old rose from 9.7 percent of the entire Medicare population in 1992 to 10.8 percent in 1998 (Figure 2-3). The oldest old has been and is expected to be one of the fastest growing subgroups of the Medicare population, due to effects of prolonged life expectancy and net immigration (U.S. Bureau of the Census, 1996).

Figure 2-2 Average Annual Growth Rates of the Medicare Population by Selected Subgroup, 1992–1998



In addition, racial/ethnic diversity within the Medicare population continued to increase. The proportion of White non-Hispanic beneficiaries gradually decreased from 84.2 percent in 1992 to 81.6 percent in 1998 (see Chapter 3, Table 6.1). While the proportion of Black non-Hispanic beneficiaries hovered around 9 percent of the Medicare population, the proportion of beneficiaries of Hispanic and other racial/ethnic origins increased steadily, rising to 6.8 percent and 2.6 percent, respectively, by 1998 (Figure 2-3).[6] Compared with the 1.5 percent average annual growth rate for the

[1] See the Section *The Sample* in *Appendix A* for a detailed explanation on the concept of *ever-enrolled* Medicare population.

[2] The *oldest old* refers to Medicare beneficiaries aged 85 and over.

[3] In the following discussion, Medicare beneficiaries are distinguished by two mutually exclusive categories: all beneficiaries under 65 years old are referred to as *disabled*, while all beneficiaries 65 years old or older are referred to as *aged*.

[4] This relatively calm period is anticipated to be followed by rapid growth in this age group as the baby boomer generation ages into the 65 and over group by 2010 and beyond.

[5] Subgroups of Medicare beneficiaries presented in Figure 2-2 and Figure 2-3 are not mutually exclusive.

[6] In the 1998 Cost and Use Public Use File (PUF), CMS refined its coding for *race* by adding the category of *more than one race* to capture data on multiracial Medicare beneficiaries. This led to a 0.25 percent increase in the 1998 estimates of the subgroup called *other race/ethnic minorities*.

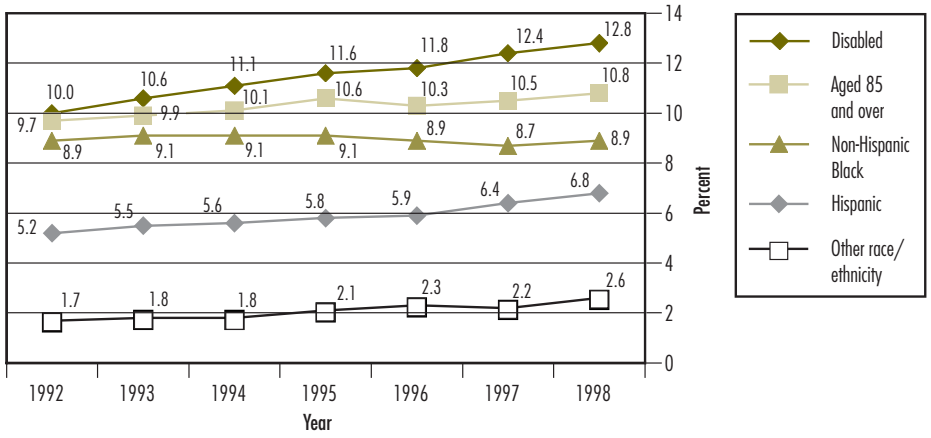
entire Medicare population between 1992 and 1998, beneficiaries of Hispanic and other racial/ethnic origins showed average annual growth rates of 6.3 and 9.8 percent, respectively (Figure 2-2). The faster growth of elderly Hispanics and other elderly race/ethnic minorities is consistent with the trend observed in the Current Population Survey (CPS) for the aged U.S. population.[7] Factors accounting for these changes include recent levels and composition of immigration to the United States, and longer life expectancy for racial/ethnic minority groups (U.S. Bureau of the Census, 1996).

Disabled Medicare beneficiaries also showed considerably higher growth rates than aged beneficiaries between 1992 and 1998 (Figure 2-1), with an average annual growth rate of 5.9 percent (Figure 2-2). In 1998, the growth slowed to 4.5 percent, but was still considerably higher than that of the aged. The percentage of total disabled beneficiaries increased from 10 percent of the Medicare population in 1992 to 12.8 percent in 1998, a net growth of 1.5 million beneficiaries (Figure 2-3).

HEALTH CARE EXPENDITURES

Personal health care expenditures (PHCE) by Medicare beneficiaries represent direct consumption of health care goods and services provided by hospitals, physicians, and other sources of medical care and equipment. The Medicare Current Beneficiary Survey (MCBS) provides estimates of expenditures for Medicare-covered services as well as some relatively expensive services not typically covered by Medicare, for example, nursing home care and prescription medicines. Information on noncovered services fills a large gap in knowledge about beneficiary health care spending. The Centers for Medicare and Medicaid Services (CMS), the primary source of Medicare program data, has claims information for only those services covered under Medicare Part A and Part B.

Figure 2-3 Proportion of Selected Groups in the Medicare Population, 1992–1998



Estimates of national health expenditures (NHE) are produced annually by CMS.[8] The NHE estimates identify all health care goods and services produced in the U.S. health care market and determine the amount spent on them. The NHE presents a comprehensive picture of national health care spending and provides information on sources of funding and services consumed by all U.S. residents. Total health care spending by the Medicare population is included in the NHE. The NHE report serves as a valuable frame of reference for policymakers to track trends in the health care industry.

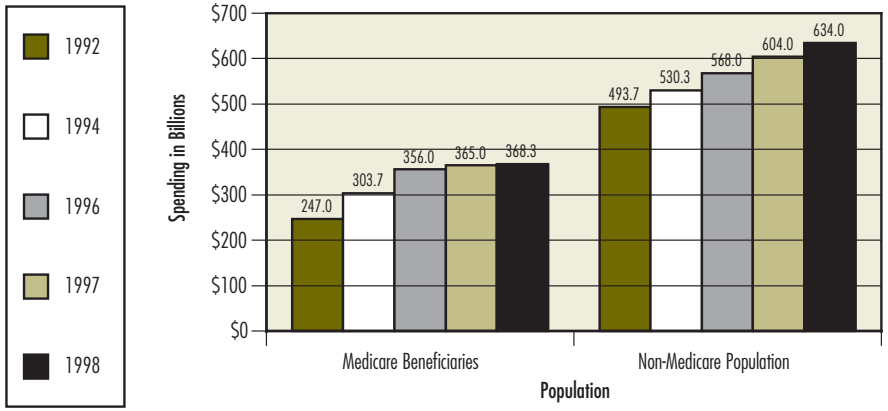
In 1998, NHE amounted to $1.1 trillion, 13.0 percent of the U.S. Gross Domestic Product (GDP). Approximately 88 percent ($1,002.3 billion) of NHE was spent on PHCE. Between 1997 and 1998, national PHCE grew by 4.5 percent, the lowest annual growth rate on record. The Medicare population, consisting of 14.6 percent of the U.S. population, spent $368.3 billion on PHCE (36.8 percent of the U.S. PHCE), while the non-Medicare population (83.4 percent of the U.S. population) spent $634 billion (63.3 percent of the U.S. PHCE) (Figure 2-4). As in previous years,

[7] It is projected that, in a couple of decades, elderly people of Hispanic origin will replace Black non-Hispanic to become the largest racial/ethnic minority group in the elderly population (U.S. Bureau of the Census, 1996).

[8] National health expenditures include personal health care expenditures, administrative costs, public health spending, and research/construction expenses.

the Medicare population consumed health care resources in amounts disproportionate to their numbers in the population. While the level of PHCE continued to rise for both the Medicare and non-Medicare populations, the *growth rate* continued to decline for the Medicare population between 1997 and 1998. PHCE incurred by them increased by less than 1 percent during this period (from $365.0 billion to $368.3 billion). This represented a sharp contrast to the double-digit growth rates recorded as recently as 1994, but was consistent with a declining growth trend evident since 1995.

Figure 2-4 National Personal Health Care Spending, 1992-1998



Between 1997 and 1998, growth of health spending by the Medicare population slowed because of low price inflation and a decline in the growth of nonprice factors (e.g., utilization inclusive of quality, technology, and service mix). Both economy-wide and medical-specific inflation rates were relatively low in recent years. Because of the robust U.S. economy, economy-wide inflation dropped to 1.0 percent in 1998, down from 1.9 percent recorded for the previous 2 years.[9] Medical-specific inflation was also modest (2.2 percent in 1998) (Levit et al., 2000).[10] Key factors that curbed price and nonprice growth included the impact of the Balanced Budget Act (BBA) of 1997, the cost containment strategies used by Medicare managed care plans along with greater enrollment in these plans, and continued government efforts in combating fraud and abuse in the Medicare Program (Heffler et al., 2001).

The phase-in of the BBA's provisions in late 1997 revised the terms of Medicare payments to health care providers, particularly hospitals, home health agencies, and skilled nursing facilities (SNFs). (See discussions below on PHCE by service type.) The BBA also restrained utilization of inpatient hospital, SNF, and home health care services by revising eligibility criteria and imposing benefit limits for these services. These measures led to the declines in health care spending on these services by Medicare beneficiaries.

Greater market penetration of managed care and the impact of its cost containment measures on the health care market helped to keep Medicare beneficiaries' total PHCE down (Gaskin and Hadley, 1997). Enrollment in Medicare managed care continued to rise in 1998, reaching 17.9 percent of the Medicare population. Consequently, Medicare managed care's cost containment practices, such as utilization review and regulated access to specialists by primary care physicians, constrained the use of health services by a growing number of Medicare beneficiaries.

In addition, other factors, such as continued government efforts to detect and reduce fraud and abuse[11] and excess capacity among certain health service providers, also may have contributed to the slower growth of PHCE (Levit et al., 2000; Heffler et al., 2001).

Although per capita PHCE for all U.S. residents continued to increase between 1997 and 1998, it remained constant for Medicare beneficiaries. Whereas per capita PHCE for the non-Medicare population climbed to $2,631, an increase of 3.8 percent from 1997, per capita spending for the Medicare population hovered around $9,200, the same level as in 1997 (Figure 2-5). Nonetheless, the level of per capita PHCE by the Medicare population was 3.5 times higher than the non-Medicare population.

[9] Economy-wide inflation is calculated using the chain-weighted GDP index with base year 1992.

[10] Medical-specific inflation is defined as the amount of price inflation specific to the medical sector of the economy that is over and above general (economy-wide) inflation.

[11] For instance, Operation Restore Trust (ORT) was launched by the Clinton administration in the mid-1990s to improve efforts at detecting and eliminating Medicare and Medicaid fraud, waste, and abuse.

Figure 2-5 Per Capita Spending on Personal Health Care, 1992–1998

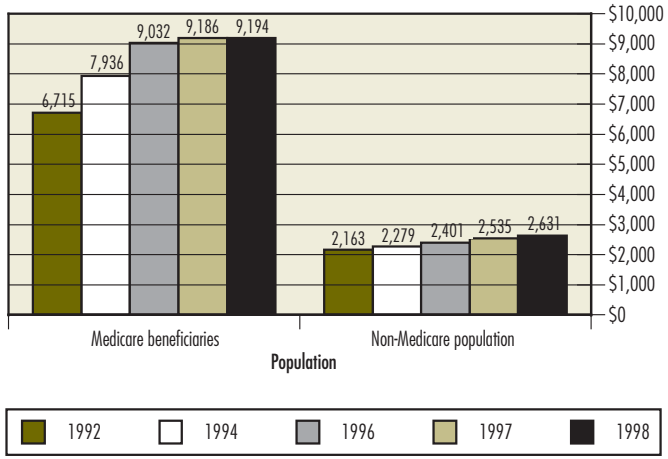


Figure 2-6 Annual Growth in Per Capita Spending on Personal Health Care, 1992–1998

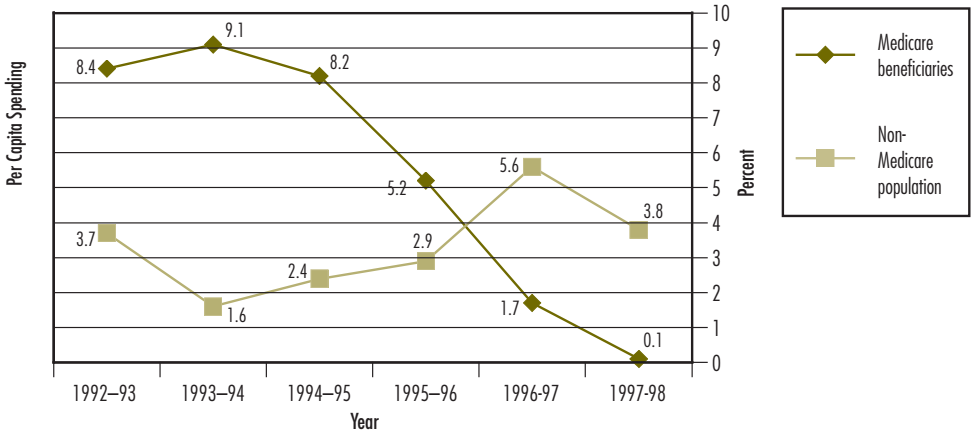
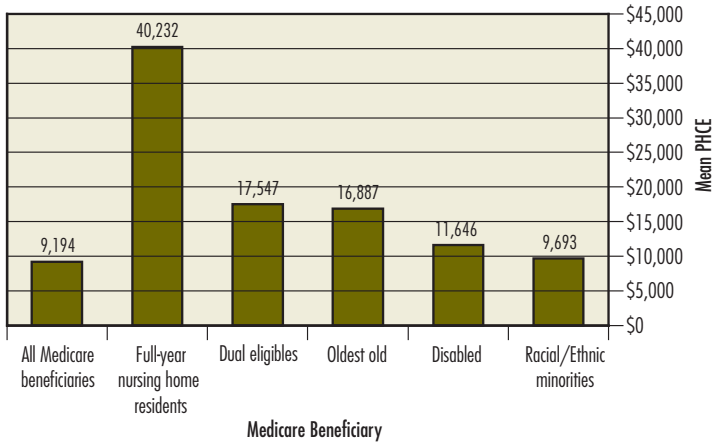


Figure 2-7 Per Capita Personal Health Care Expenditures for Selected Groups of Medicare Beneficiaries, 1998



As in the previous year, the *growth* in per capita spending for the Medicare population was below that of the non-Medicare population between 1997 and 1998 (Figure 2-6). Both groups' growth rates declined during this period. The slower per capita spending growth resulted in the marked slow growth in Medicare beneficiaries' aggregate PHCE. Real growth (general inflation adjusted) in per capita PHCE for the Medicare population also decelerated during this time, posting a decline of 0.9 percent, the second consecutive year of negative real growth.[12]

Because of their significant health care needs, some segments of the Medicare population (often identified as vulnerable subpopulations) tend to incur higher than average per capita PHCE. These include full-year nursing home (long-term care facility) residents, Medicare/Medicaid dual eligibles, the oldest old, the disabled, and racial/ethnic minorities. In 1998, the pattern of per capita health care spending by these groups was similar to the patterns observed in previous years (Figure 2-7).[13]

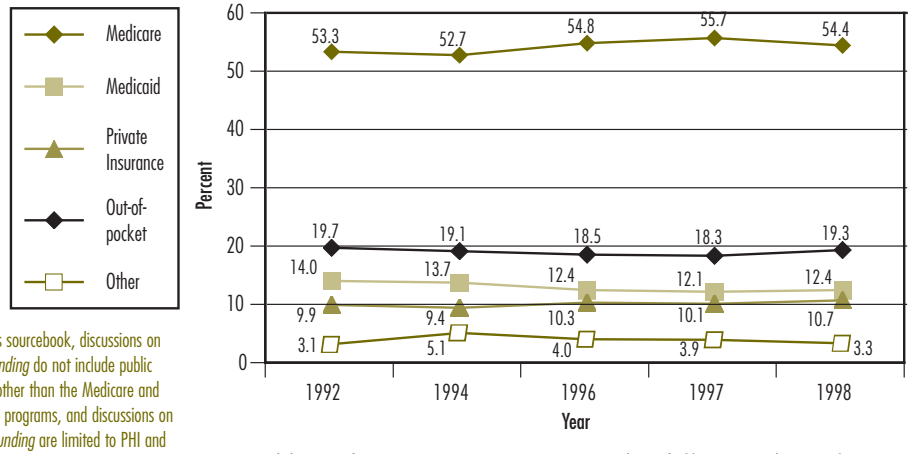
[12] Real growth of health care spending is defined as the product of quantity and intensity of health care services purchased and changes in medical price inflation in excess of economy-wide inflation. That is: Real PHCE=(Excess Medical Price Inflation)x(Quantity and Intensity of Health Care Services). Real growth in PHCE is computed as follows: using the chain-type GDP deflator with 1992 base year as the general inflation index, current year dollars are converted into real (1992) dollars by dividing current year dollars by the price index value for the same year. The annual percent growth, using the prior year as the reference year, may then be calculated using real dollars.

[13] The subgroups of beneficiaries presented in this figure are not mutually exclusive.

FUNDING SOURCES

Medicare beneficiaries fund their total expenditures on health care with public as well as private sources. Public resources consist largely of payments by Federal, state, and local governments through the Medicare and the Medicaid programs and other publicly funded programs. Private resources include payments by private health insurance (PHI), funds paid directly by beneficiaries out-of-pocket (OOP), and from other private sources such as charitable foundations. The financing pattern of PHCE for Medicare beneficiaries remained relatively stable between 1992 and 1998 (Figure 2-8). In 1998, the share of total PHCE paid by Medicare dropped to 54.4 percent after reaching a high of 55.7 percent in 1997. In contrast, shares paid by PHI and OOP inched up in 1998, reaching 10.7 and 19.3 percent, respectively.

Figure 2-8 Sources of Funds for Personal Health Care Expenditures by Medicare Beneficiaries, 1992–1998



Public and private payment sources play different roles in financing health care for the Medicare and non-Medicare populations.[14,15] In 1998, public funding, in the form of Medicare and Medicaid payments, covered 66.7 percent of PHCE by the Medicare population and private funding covered 30.0 percent (Figure 2-9). In contrast, for the non-Medicare population, public funding provided only 18.3 percent, while private sources financed 63.4 percent of total PHCE (CMS, 2001, Table 4). The difference was due to the fact that Medicare beneficiaries financed more than half of their health care cost with Medicare funds, while the non-Medicare population covered close to half of their costs with PHI funds.

Figure 2-9 Sources of Funds for Personal Health Care Expenditures by Medicare Beneficiaries and the Non-Medicare Population, 1998

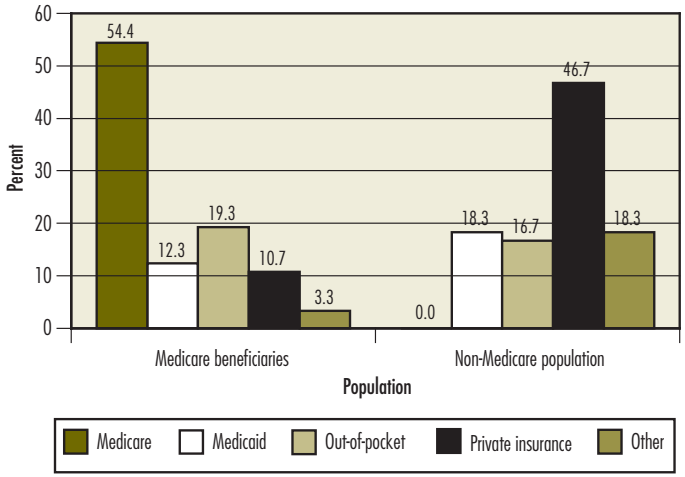


Figure 2-10 illustrates the annual growth rates of PHCE of Medicare beneficiaries financed by public versus private sources. The annual growth rates for public funding began falling gradually in 1994, followed by sharp declines between 1995 and 1998. In contrast, annual growth rates for private funding, except for the plunge between 1996 and 1997, remained relatively stable at around 7–9 percent.

In 1998, two-thirds of PHCE incurred by the Medicare population was funded by public sources. Medicare, through the hospital insurance and supplementary medical insurance programs,

[14] In this sourcebook, discussions on *public funding* do not include public sources other than the Medicare and Medicaid programs, and discussions on *private funding* are limited to PHI and OOP payments.

[15] To achieve comparability between the Medicare and non-Medicare populations, *other private payments* in NHE were collapsed with *other public* to become payments from *other sources*.

continued to be the predominant payer (54.4 percent) (Figure 2-8). However, due to the impact of BBA and administrative measures to fight fraud and abuse, Medicare payments declined 1.5 percent between 1997 ($203.3 billion) and 1998 ($200.2 billion). Per capita Medicare payment, which was $4,997 in 1998, showed a slightly larger decrease, falling 2.3 percent during the same time period. Medicaid, acting as a supplemental health insurance as well as the primary payer for Medicare noncovered services for eligible beneficiaries, financed another 12.4 percent of PHCE for Medicare beneficiaries.

In contrast to the trend of declining payments from Medicare, payments from both PHI and OOP sources increased markedly between 1997 and 1998, after relatively flat growth between 1996 and 1997. In 1998, total PHI payments amounted to $39.3 billion, representing a growth of 7.1 percent from 1997. At the same time, total OOP payments rose by 6.4 percent from 1997 to $71.1 billion. In 1998, average OOP payments by Medicare beneficiaries ($1,774) remained 4 times higher than payments by the non-Medicare population ($447). Per capita OOP payments varied dramatically among subgroups of Medicare beneficiaries. For example, in 1998, per capita OOP payments for the aged and disabled community residents amounted to $1,208 and $1,227 respectively, compared with $12,793 for full-year nursing home residents.

Figure 2-11 depicts sources of funding for aged and disabled Medicare beneficiaries residing in communities, and for full-year nursing home residents. Aged and disabled community residents reported similar funding patterns in 1998. Medicare financed the bulk of health care services for these two groups, 65.3 percent and 57.3 percent, respectively. However, Medicaid funded a significantly larger share of health care expenditures for disabled beneficiaries than for the aged, 12.2 percent versus 2.9 percent, respectively. The distribution of shares by funding source was different for full-year nursing home residents. Medicaid was the

Figure 2-10 Annual Growth Rates for Personal Health Care Expenditures by Medicare Beneficiaries by Funding Source, 1992–1998

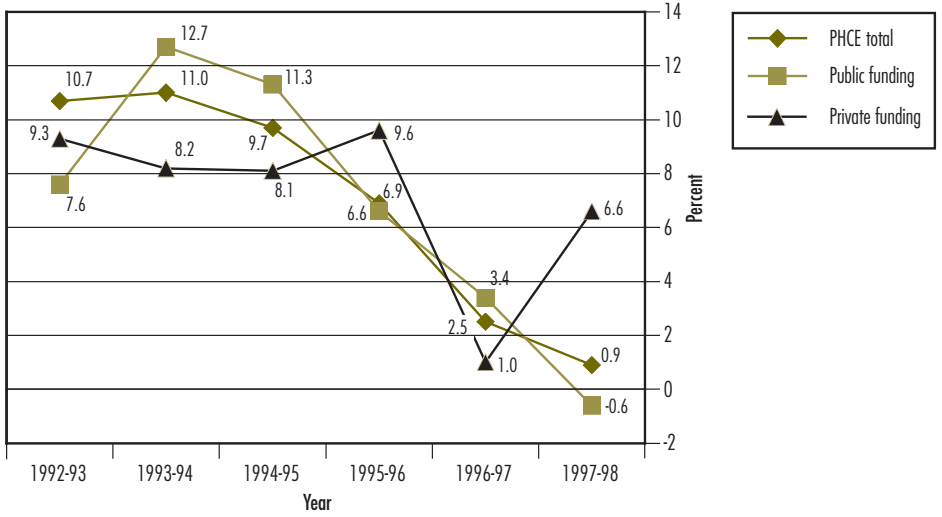
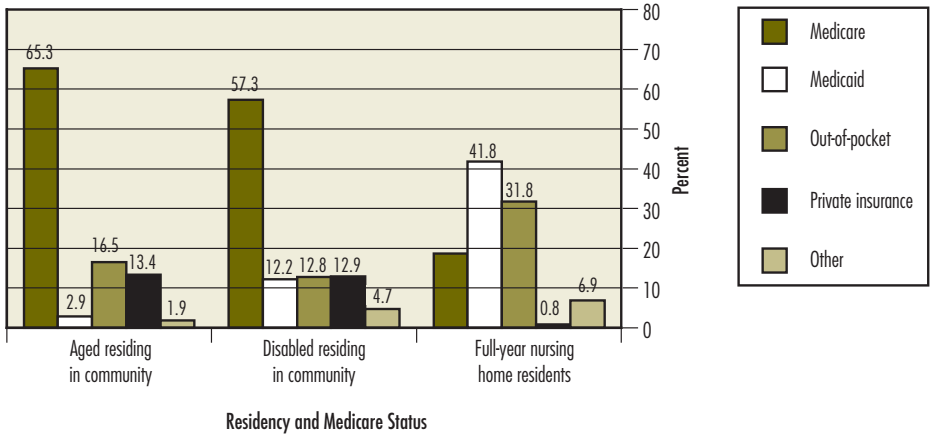


Figure 2-11 Sources of Funds for Personal Health Care Expenditures by Residency and Medicare Status, 1998

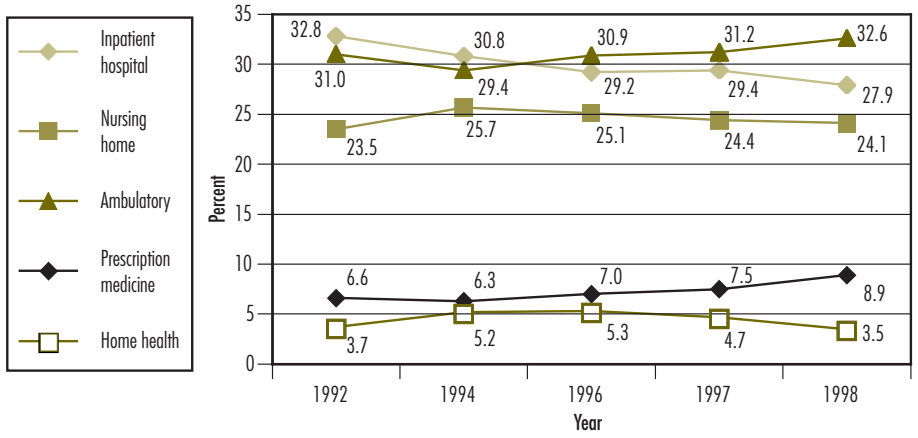


primary funding source of their PHCE (41.8 percent), followed by beneficiaries' OOP payments (31.8 percent), and Medicare (18.6 percent). Although approximately 22 percent of full-year nursing home residents were covered by PHI, its share of their PHCE was negligible.

PHCE BY SERVICE CATEGORY

The Medicare population uses many types of health services, often in quantities disproportionate to their numbers in the population. Shares of PHCE across the spectrum of health services changed somewhat in recent years for Medicare beneficiaries (Figure 2-12).

Figure 2-12 Proportion of Personal Health Care Spending by Medicare Beneficiaries by Selected Type of Service, 1992–1998



From 1992 to 1998, the share of total PHCE for inpatient hospital care declined, while the share of ambulatory care increased.[16] Other noteworthy changes included the rising share of prescription medicine spending, and the declining share of home health care spending since 1996. A deceleration in the growth of Medicare beneficiaries' total health care spending partly reflected the reduced spending on inpatient hospital, home health, and SNF services.

In 1998, Medicare beneficiaries' spending on inpatient hospital services declined 4.1 percent from 1997, the first decline since the early 1990s (Table 2-1). Reduced inpatient hospital spending by Medicare beneficiaries was likely to be the outcome of revised inpatient hospital payment incentives under the BBA and greater participation in Medicare HMO plans. The BBA's 1-year freeze on Prospective Payment System (PPS) rates for inpatient services clearly restrained spending on these services. Moreover, the average complexity of Medicare PPS inpatient admissions declined slightly in 1998, probably due to changes in hospital DRG coding practices prompted by fraud and abuse investigations by the government (Heffler et al., 2001). Growing enrollment in Medicare managed care plans during this period also contributed to the decline in inpatient spending by Medicare beneficiaries. These plans actively negotiated discounts from hospital providers. Policy and structural changes in the health care industry prompted hospitals to downsize or consolidate in order to reduce excess capacity. Medicare managed care plans also contained spending

Table 2-1 Annual Growth Rate of Spending by Selected Service Type, 1992–1998

	1992–93 (%)	1993–94 (%)	1994–95 (%)	1995–96 (%)	1996–97 (%)	1997–98 (%)
Inpatient Hospital	6.9	8.0	5.7	5.0	3.3	-4.1
Ambulatory	4.5	11.6	17.6	4.7	3.4	5.4
Physician/Supplier	3.7	11.0	16.8	4.4	1.8	5.5
Outpatient Hospital	6.8	13.2	19.9	5.5	7.9	5.3
Prescription Medicine	9.2	8.7	12.2	14.5	10.5	20.6
Home Health	26.3	35.8	11.7	6.7	-8.1	-25.4
Nursing Home	22.6	9.7	4.7	9.0	0.0	-0.5
Long-term Care	20.8	5.6	4.3	5.5	-2.8	1.5
Skilled Nursing Facility	46.2	54.5	8.1	33.9	15.8	-9.8

[16] Ambulatory care services include physician\supplier services and outpatient hospital services.

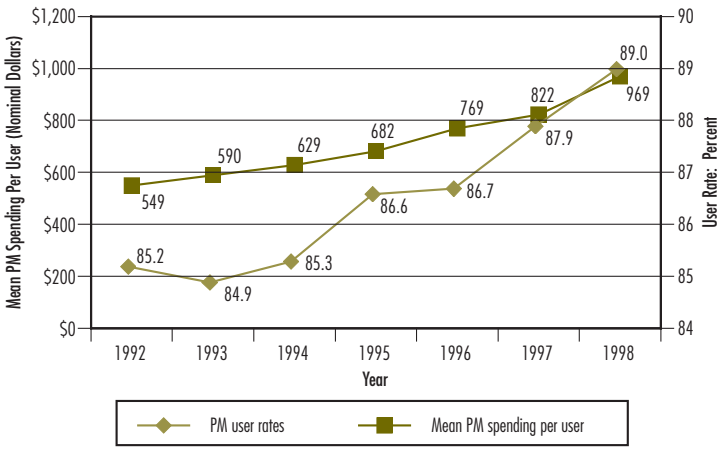
growth by employing cost-control practices, such as inpatient utilization review and site-of-care substitution, that is, substituting health care services in outpatient settings for more expensive inpatient services (Levit et al., 2000; Heffler et al., 2001).

Growth of spending for physician/supplier services by Medicare beneficiaries rose from 1.8 percent in 1997 to 5.5 percent in 1998 (Table 2-1). This occurred mainly because of structural changes in the health care provider market. Greater physician/supplier participation in managed care, along with site-of-care substitution, may have fueled spending growth. Lower beneficiary OOP costs under managed care increased access to and demand for physician services. Consequently, under Medicare's capitated payments to managed care plans, physician services accounted for about a 40 percent share, double the share under fee-for-service payments (Cowan et al., 1999). In light of the increasing proportion of Medicare beneficiaries enrolled in managed care, growth in spending on physician services was expected.

In contrast, growth of Medicare beneficiaries' hospital outpatient spending slowed to 5.3 percent between 1997 and 1998 (Table 2-1), perhaps in response to BBA's payment adjustments for Medicare outpatient services. Nevertheless, the relatively high level of growth was the outcome of new technological developments and revised provider incentives to transfer more services or procedures to outpatient settings. Many services previously available only as inpatient procedures became more available in hospital outpatient departments (Welch, 1998).

From 1995 through 1998, prescription medicine (PM) spending by the Medicare population consistently grew at double-digit rates, faster than any other type of personal health care spending (Table 2-1). In 1998, the PM's share reached 8.9 percent of Medicare beneficiaries' PHCE (Figure 2-12). The rapid growth was fueled by several developments. The increased rate of PM coverage among the Medicare population undoubtedly boosted demand for PMs.[17]

Figure 2-13 Prescription Medicine Utilization by Noninstitutionalized Medicare Beneficiaries, 1992–1998



Increasing enrollment in managed care, which typically offers PM coverage and requires relatively low PM co-payments, further raised demand for PMs. As a result, between 1992 and 1998, both PM user rates and per capita nominal spending on PMs for users increased steadily among Medicare beneficiaries residing in communities (Figure 2-13). Thus, a large portion of the recent dramatic growth in PM spending was attributable to higher PM utilization rates (Heffler et al., 2001).

Accelerated drug spending may also have been the result of changes in the Food and Drug Administration's (FDA) drug approval process that speeds the introduction of new drugs to the market, thus prompting physicians and consumers to substitute newer, higher priced brand-name drugs for less expensive ones. Another important factor behind drug spending growth, perhaps working in concert with rapid introduction of new drugs, was the rapid growth in direct-to-consumer advertising expenditures by pharmaceutical manufacturers, boosting demand for well-publicized drugs (Levit et

[17] Previous research showed that the presence of third-party coverage of PMs raised the likelihood that the insured filled prescriptions. In 1998, nearly two-thirds of Medicare beneficiaries had some drug coverage (Poisal et al., 1999).

al., 2000). Moreover, increased access to physician services under managed care may have led to increased PM use, since a physician visit is often necessary to obtain a prescription. Drug therapy may be a more cost-effective way for managed care plans to treat plan members for certain conditions that might require more involved and expensive treatment later if left untreated (Cowan et al., 1999).

Between 1992 and 1998, spending for home health services showed great volatility, largely due to shifts in the Medicare home health care policies (Table 2-1). In the late 1980s and early 1990s, Medicare liberalized eligibility criteria for home health care services and relaxed restrictions on the number of visits per beneficiary. These changes triggered soaring growth in home health spending in the early 1990s (Langa et al., 2001). Since 1994, however, spending decreased sharply in response to a series of administrative cost-control measures,[18] intensified government activities to counter fraud and abuse, and Medicare policy changes mandated in the BBA. Specifically, the BBA reduced Medicare payment rates to home health agencies, restricted access to their services, and implemented a cost-containing interim payment system until a PPS for home health services was in place (Levit et al., 2000). Collectively, these measures led to some of the consolidations, mergers, and closures in the industry. Medicare, the largest single payer of home health services, reduced its level of funding on home health care services, as both the home health care user rates and the average number of services for users declined among Medicare beneficiaries in 1998.

Medicare beneficiaries' spending on nursing home care, including services received at both long-term care facilities and SNFs, dropped by 0.5 percent in 1998 (Table 2-1). However, underlying the negative growth in total nursing home spending was a 1.5 percent growth in spending on its major component—long-term facility care. Since Medicaid is the major payer of long-term care, changes in State Medicaid payment and coverage policies affect spending on all long-term care. The modest growth in long-term care may reflect continued efforts by the states to encourage greater use of lower cost long-term care options, such as home health service, assisted living facilities, and community-based day care. However, revised Medicare home health care rules under the BBA may have prompted some beneficiaries who lack alternative sources of care to use long-term care instead.

The main reason for the decline in nursing home spending between 1997 and 1998 was the 9.8 percent reduction in spending on SNF care (Table 2-1), the first since the early 1990s. To counter the alarming growth in Medicare SNF spending between 1991 and 1996, the BBA mandated several changes to curb rising Medicare payments to SNFs, effective October 1997. For instance, the BBA mandated a prospectively determined per diem Medicare payment rate in the place of reasonable cost-based payment. It also required all SNF services be bundled into a single per diem payment. During a 3-year phase-in period after the enactment of the BBA in 1997, Medicare payments to SNFs were based on a changing blend of facility-specific and national per diem amounts. Thus changes mandated by the BBA, as well as government activities to reduce fraud and abuse, sharply reduced Medicare beneficiaries' SNF spending between 1997 and 1998 (Levit et al., 2000).

INSURANCE STATUS

Supplemental health insurance is important to Medicare beneficiaries, because Medicare does not cover certain health care services, such as prescription medicines and long-term care. A large proportion of Medicare beneficiaries have some form of supplemental health insurance to ensure better coverage for their health care needs. Research indicates that the presence of supplemental health insurance tends to increase utilization rates and spending on covered health services (Poisal et al., 1999; Khandker and McCormack, 1999).

[18] These administrative measures included tightening controls over home health agencies (HHAs), such as revising the Medicare Conditions of Participation (CoPs) for HHAs, requiring that HHAs collect information relating to an Outcomes and Assessment Standard Information Set (OASIS), revising the HHA Manual, and increasing physician and beneficiary outreach in the monitoring of home health care services.

Between 1992 and 1998, increasing Medicare HMO enrollment among Medicare beneficiaries coincided with decreasing coverage from PHI (Figure 2-14). During this period, Medicare HMO enrollment went through periods of rapid growth, when average annual growth rates reached 18.8 percent. Growth decelerated between 1997 and 1998 to 13.5 percent, probably because of less availability of Medicare HMOs in certain geographic areas due to withdrawal or termination of health plans (Cowan et al., 1999). By 1998, an estimated 18.4 percent of noninstitutionalized Medicare beneficiaries were enrolled in a Medicare HMO, representing 7 million beneficiaries.

Concurrent with this trend, PHI enrollment, in particular individually-purchased PHI, declined steadily among Medicare beneficiaries. Between 1992 and 1998, the proportion of noninstitutionalized Medicare beneficiaries with individually-purchased PHI decreased more than 7 percentage points, from 37.8 percent in 1992 to 30.7 percent in 1998 (Figure 2-14). At the same time, beneficiaries with employer-sponsored PHI also showed modest yet steady decreases, a 2.6-percentage-point reduction between 1992 and 1998. These trends suggest a continued shift by Medicare beneficiaries away from PHI and toward Medicare managed care (Sharma et al., 2001). This trend may reflect a response to the rising PHI premiums, relatively high OOP costs, and limited benefits that accompany standard indemnity PHI coverage, especially for individually-purchased policies.

In 1998, patterns of supplemental health insurance coverage of noninstitutionalized Medicare beneficiaries across age groups were comparable with those in 1997 (Figure 2-15). Among the aged, participation in Medicare HMO and employer-sponsored PHI declined, whereas enrollment in individually-purchased PHI increased as age advanced. These patterns may reflect a combination of factors, including favorable selection by the managed care organizations and self-selection by beneficiaries. Compared with the aged, Medicare fee-for-service-only coverage

Figure 2-14 Trends of Private Health Insurance and Medicare HMO Coverage for Noninstituionalized Medicare Beneficiaries, 1992–1998

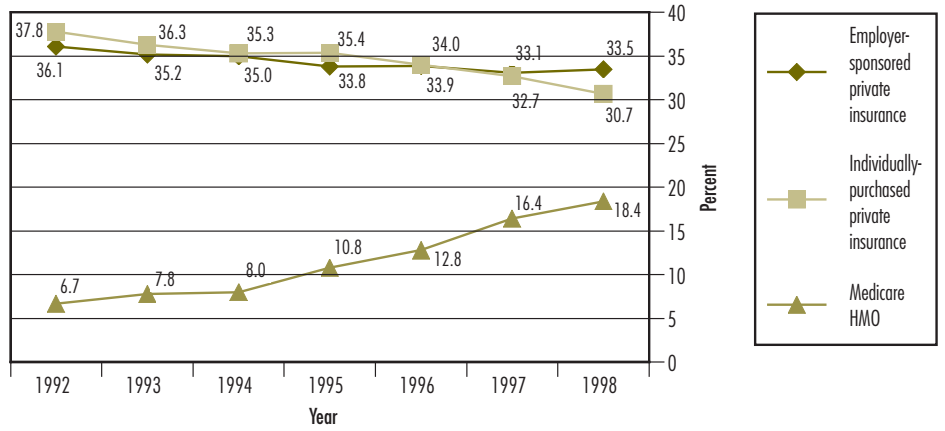
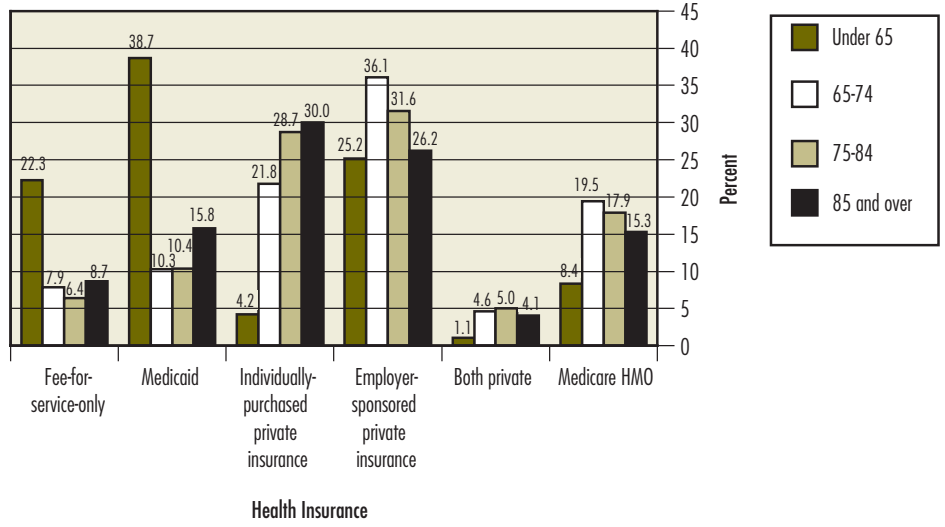


Figure 2-15 Health Insurance Coverage of Noninstitutionalized Medicare Beneficiaries by Age Group, 1998



and dual Medicare and Medicaid coverage were significantly more prevalent among the disabled beneficiaries (22 and 39 percent, respectively) than the overall aged population. However, coverage from individually-purchased PHI and Medicare HMO was significantly less common among the disabled beneficiaries (4 and 8 percent, respectively).

SUMMARY

While the entire Medicare population grew modestly in recent years, several vulnerable subgroups of Medicare beneficiaries grew much more rapidly, including the oldest old, Hispanics, beneficiaries of other race/ethnicity, and the disabled. As a result, the Medicare population is becoming increasingly diverse, as the proportions of various subgroups continue to expand.

Between 1997 and 1998, growth of PHCE by Medicare beneficiaries continued the declining trend evident since 1995. The growth rate of per capita PHCE by Medicare beneficiaries remained below that of the non-Medicare population for a second consecutive year, although per capita PHCE for Medicare beneficiaries remained considerably higher than that of the non-Medicare population in 1998. Sharply reduced levels of public funding, Medicare in particular, accounted for the low growth in PHCE by Medicare beneficiaries. In contrast, the annual growth rate for private funding remained close to its historical levels.

Shares of PHCE by type of service for Medicare beneficiaries shifted between 1992 and 1998. The share of spending on inpatient hospital services steadily declined, while the shares of ambulatory care and PMs increased. The share of home health care spending continued the decline that began in 1996. In 1998, major service types showing declines in spending levels included inpatient hospital, home health care, and SNF services.

Several key factors may have accounted for the low growth of PHCE by Medicare beneficiaries and declines in the spending level of certain service types: the implementation of the cost-containment provisions of the BBA, greater beneficiary enrollment in Medicare managed care, cost-containment strategies used by managed care plans, and intensified government activities to combat fraud and abuse.

However, faster growth in PM and ambulatory spending in 1998 may be primarily a result of structural changes in the health care market, including increased coverage, lower access barriers, site-of-care substitution, and lower OOP burdens on Medicare beneficiaries.